



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

*Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.*

### When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- Benefits are available in the member's contract/certificate, and
- Medical necessity criteria and guidelines are met.

**\*\*\*Note: The Eastern Cooperative Oncology Group (ECOG) Performance Status and Karnofsky Performance Status Scales can be found in the Background/Overview section.**

### STEREOTACTIC RADIOSURGERY (SRS)

#### Bone Metastases

Based on review of available data, the Company may consider stereotactic radiosurgery (SRS) for treatment of bone metastases to be **eligible for coverage** for the following criteria:

#### Patient Selection Criteria

Coverage eligibility for stereotactic radiosurgery (SRS) for bone metastases may be considered when **ALL** of the following criteria are met:

- To treat a previously irradiated field; **AND**
- Re-treatment with 2D or 3D conformal external beam radiation therapy (EBRT) would result in significant risk of spinal cord injury (e.g. cumulative spinal cord dose >50 Gy in 2 Gy equivalent).

#### Cranial Lesions

Based on review of available data, the Company may consider stereotactic radiosurgery (SRS) for treatment of cranial lesions to be **eligible for coverage** for the following criteria:

#### Patient Selection Criteria

Coverage eligibility for stereotactic radiosurgery (SRS) for cranial lesions may be considered when **ANY** of the following criteria are met:

- Intracranial lesions
  - High grade gliomas (grade 3-4) in individuals with good performance status (**based on either of the following**):
    - ECOG 0, 1, or 2; **OR**
    - Karnofsky Scale greater than or equal to 70%;

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

### AND

When one of the following conditions is met:

- Recurrent disease; **OR**
- To treat a previously irradiated field.

### OR

- Low grade gliomas (grade 1-2) in individuals with good performance status **(based on either of the following)**:
  - ECOG 0, 1, or 2; **OR**
  - Karnofsky Scale greater than or equal to 70%;

### AND

When one of the following conditions is met:

- Initial treatment; **OR**
- Recurrent disease; **OR**
- To treat a previously irradiated field;

### OR

- Medulloblastoma, supratentorial primitive neuroectodermal tumors (PNET), Ependymoma, Central nervous system (CNS) lymphoma- only to treat a previously irradiated field;

### OR

- Metastatic brain lesions when any of the conditions are met:
  - For individuals with good performance status **(based on either of the following)**:
    - ECOG 0, 1, or 2: **OR**
    - Karnofsky Scale greater than or equal to 70%;

### OR

- To treat a previously irradiated field;

### OR

- Benign brain lesions:
  - Arteriovenous malformations (AVMs), Acoustic neuromas, Craniopharyngeomas, Pineal gland tumors, Schwannomas;

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

### OR

- Pituitary adenomas when any of the following conditions are met:
  - When individual is symptomatic; **OR**
  - To treat a previously irradiated field.

### OR

- Meningioma when any of the following conditions are met:
  - When lesion is unresectable or recurrent, or if there is residual disease following surgery; **OR**
  - To treat a previously irradiated field;

### OR

- Trigeminal neuralgia when any of the following conditions are met:
  - o When symptoms are refractory to standard medical management; **OR**
  - o To treat a previously irradiated field;

### OR

- Uveal melanoma when any of the following conditions are met:
  - o For treatment of melanoma of the choroid; **OR**
  - o To treat a previously irradiated field.

### **Other Malignancies**

Based on review of available data, the Company may consider stereotactic radiosurgery (SRS) for treatment of malignancies listed below **ONLY** to treat a previously irradiated field to be **eligible for coverage**:

#### Patient Selection Criteria

Coverage eligibility for stereotactic radiosurgery (SRS) **ONLY** to treat a previously irradiated field may be considered for **ANY** of the following conditions:

- Hodgkin or Non-Hodgkin lymphoma; **OR**
- Pediatric malignancies (age less than 21)
  - o Note: For intracranial malignancy see criteria listed above, in section 'Intracranial lesions'; **OR**
- Sarcoma; **OR**
- Thymoma and thymic carcinoma.

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

### **STEREOTACTIC BODY RADIOTHERAPY (SBRT)**

#### **Bone Metastasis**

Based on review of available data, the Company may consider stereotactic body radiotherapy (SBRT) for treatment of bone metastases to be **eligible for coverage** for the following criteria:

#### Patient Selection Criteria

Coverage eligibility for stereotactic body radiotherapy (SBRT) for bone metastases may be considered when **ALL** of the following criteria are met:

- To treat a previously irradiated field; **AND**
- Re-treatment with 2D or 3D conformal external beam radiation therapy (EBRT) would result in significant risk of spinal cord injury (e.g. cumulative spinal cord dose >50 Gy in 2 Gy equivalent).

#### **Central Nervous System (CNS) - Primary or Metastatic Spine Lesions**

Based on review of available data, the Company may consider stereotactic body radiotherapy (SBRT) for treatment of spine lesions to be **eligible for coverage** when either of the following criteria are met:

#### Patient Selection Criteria

Coverage eligibility for stereotactic body radiotherapy (SBRT) for spine lesions may be considered when **EITHER** of the following criteria are met:

- When other treatment options are not available (**both must be met**)
  - Not amenable to surgical resection (**at least one must apply**)
    - Related to prior surgery, tumor location, or surgical candidacy; **OR**
    - Surgery alone is not an option;

**AND**

- When lesions are not amenable to 3D conformal techniques;

**OR**

- To treat a previously irradiated field.

#### **Liver Cancer - Hepatocellular Carcinoma or Liver Metastases**

Based on review of available data, the Company may consider stereotactic body radiotherapy (SBRT) for treatment of liver cancer to be **eligible for coverage** when following criteria are met:

#### Patient Selection Criteria

Coverage eligibility for stereotactic body radiotherapy (SBRT) for liver cancer may be considered when **ANY** of the following criteria are met:

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

- o Hepatocellular carcinoma (HCC)
  - As palliative treatment for individuals with liver-related symptoms after other therapy options have been exhausted;

**OR**

- As treatment of up to 3 lesions, as an option to surgery or embolization when these therapies have been done and have failed, or are contraindicated, when **ALL** of the following conditions are met:
  - Diameter less than 6 cm; **AND**
  - Patients with Child-Pugh category A or B; **AND**
    - ❖ *Note: SBRT has not been established as a safe treatment option in patients with Child-Pugh category C cirrhosis*
  - Individual has a good performance status (ECOG 0-2, Karnofsky 70% or greater);

**OR**

- To treat a previously irradiated field;

**OR**

- o Liver metastases
  - As palliative treatment for individuals with liver-related symptoms
    - Particularly after other therapy options have been exhausted; **OR**
  - To treat a previously irradiated field.

### **Lung Cancer- Non-Small Cell Lung Cancer (NSCLC), Small Cell Lung Cancer, Lung Metastasis**

Based on review of available data, the Company may consider stereotactic body radiotherapy (SBRT) for treatment of lung cancer to be **eligible for coverage** when following criteria are met:

#### Patient Selection Criteria

Coverage eligibility for stereotactic body radiotherapy (SBRT) for lung cancer may be considered when **ANY** of the following criteria are met:

- o Non-small cell lung cancer (NSCLC)
  - For an alternative to surgical resection when **(all must apply)**
    - Treatment intent is cure; **AND**
      - ❖ There is no evidence of nodal or distant metastases based on conventional staging techniques (Stage IA, IB, or IIA with negative lymph nodes); **AND**
    - Single lesion measuring less than or equal to 5 cm; **AND**

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

- Lesion is inoperable **for ANY of the following reasons:**
  - ❖ Tumor location; **OR**
  - ❖ Individual is not a surgical candidate due to a medical contraindication;

**OR**

- To treat a previously irradiated field;

**OR**

- o Small cell lung cancer
  - Only to treat a previously irradiated field;

**OR**

- o Metastatic lesions in the lung
  - To treat a metastatic lesion (**all must be met**)
    - Patient with a single metastatic lesion measuring less than 5 cm; **AND**
      - ❖ Oligometastatic disease may be considered on a case-by-case basis; **AND**
    - Individual has a good performance status (**either must apply**)
      - ❖ ECOG Scale 0, 1, or 2; **OR**
      - ❖ Karnofsky Scale greater than or equal to 70%; **AND**
    - Extrapulmonary disease is stable or volume of disease is low with remaining treatment options; **AND**
    - Intent is either:
      - ❖ Curative; **OR**
      - ❖ Palliative, with a current symptom or anticipation of a symptom (for example, lesion is close to a major vessel and without local treatment, is anticipated to lead to hemoptysis or hemorrhage);

**OR**

- To treat a previously irradiated field.

### **Prostate Cancer**

Based on review of available data, the Company may consider stereotactic body radiotherapy (SBRT) for treatment of prostate cancer to be **eligible for coverage** when following criteria are met:

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

### Patient Selection Criteria

Coverage eligibility for stereotactic body radiotherapy (SBRT) for prostate cancer may be considered when **ANY** of the following conditions and criteria are met:

o Low-risk of recurrence (**all must be present to qualify as low-risk**)

- Stage T1 –T2a; **AND**
- Gleason Score of 6; **AND**
- Prostate-specific Antigen (PSA) below 10 ng/mL;

**AND**

- When anticipated survival is greater than 10 years; **OR**
- To treat a previously irradiated field;

*Note: Active surveillance is a reasonable alternative to radiation treatment in individuals with low risk prostate cancer.*

**OR**

o Intermediate-risk of recurrence (**any one characteristic**)

- Stage T2b to T2c; **OR**
- Gleason score of 7; **OR**
- PSA 10-20 ng/mL;

**AND**

- When anticipated survival is greater than 10 years; **OR**
- To treat a previously irradiated field;

**OR**

o High or very high risk of recurrence (**any one characteristic**)

- Stage T3a; **OR**
- Gleason score of 8-10; **OR**
- PSA greater than 20ng/mL;

**AND**

- Only to treat a previously irradiated field;

**OR**

o Post-prostatectomy

- Only to treat a previously irradiated field;

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

### OR

- o Local recurrence
  - Only to treat a previously irradiated field.

### Other Malignancies

Based on review of available data, the Company may consider stereotactic body radiotherapy (SBRT) for malignancies listed below ONLY to treat a previously irradiated field to be **eligible for coverage**:

### Patient Selection Criteria

Coverage eligibility for stereotactic body radiotherapy (SBRT) ONLY to treat a previously irradiated field may be considered for **ANY** of the following conditions:

- Head and neck cancers, including thyroid cancer; **OR**
- Hodgkin and Non-Hodgkin lymphoma; **OR**  
Colorectal cancer (CRC) and anal cancer; **OR**
- Other gastrointestinal (GI) cancers, e.g. cholangiocarcinoma, esophageal, gastric, pancreatic; **OR**
- Genitourinary cancers, e.g. bladder, penile, testicular; **OR**
- Gynecologic (GYN) cancers, e.g. cervical, fallopian tube, ovarian, uterine neoplasms, vulvar/vaginal; **OR**
- Pediatric malignancies (age less than 21); **OR**
- All other malignancies.

### **When Services Are Considered Not Medically Necessary**

*Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.*

The use of stereotactic radiosurgery (SRS) or stereotactic body radiotherapy (SBRT) when patient selection criteria are not met is considered to be **not medically necessary**.\*\*

### Background/Overview

#### **\*\*\*The ECOG Performance Status and Karnofsky Performance Status Scales**

ECOG PERFORMANCE STATUS	KARNOFSKY PERFORMANCE STATUS
0—Fully active, able to carry on all pre-disease performance without restriction	100—Normal, no complaints; no evidence of disease
	90—Able to carry on normal activity; minor signs or

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.





# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

	symptoms of disease
1—Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work	80—Normal activity with effort, some signs or symptoms of disease  70—Cares for self but unable to carry on normal activity or to do active work
2—Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours	60—Requires occasional assistance but is able to care for most of personal needs  50—Requires considerable assistance and frequent medical care
3—Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours	40—Disabled; requires special care and assistance 30—Severely disabled; hospitalization is indicated although death not imminent
4—Completely disabled; cannot carry on any selfcare; totally confined to bed or chair	20—Very ill; hospitalization and active supportive care necessary 10—Moribund
5—Dead	0—Dead

*Note: The ECOG Performance Status and Karnofsky Performance Status Scales are widely used to evaluate the functional status of cancer patients to determine their eligibility for clinical trials and their prognosis.*

### **Bone Metastases**

#### **Initial Treatment**

Metastasis to the bony skeleton is a common site of spread for many solid tumors including breast, prostate and lung cancers. Bone metastases can be seen with any cancer histology and affects more than 250,000 patients per year in the United States. It has been estimated that up to 80% of patients with solid cancers will develop painful bone metastases to the pelvis, spine or extremities during the course of their illness. Metastases to the bone can cause accelerated bone breakdown which may result in pain, pathologic fracture and nerve or spinal cord compression resulting in sensory loss or motor weakness. Laboratory abnormalities may include hypercalcemia and myelosuppression. Radiation therapy has long been used to palliate pain and other symptoms of bone metastases with excellent results.

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

SBRT or stereotactic ablative body radiotherapy (SABR) is being studied in the treatment of bony metastatic disease. Proposed indications for this modality include standalone or postoperative treatment in patients with progressive or recurrent disease following conventional external beam radiotherapy (cEBRT) and in the treatment of tumors traditionally considered radioresistant to cEBRT such as sarcoma, melanoma and renal cell carcinoma. The Radiation Therapy Oncology Group (RTOG) is currently conducting a comparison of SBRT with a single fraction of 8 Gy for painful vertebral metastasis. The updated the American Society for Radiation Oncology (ASTRO) evidence based guideline maintains that: "Advanced radiation therapy (RT) techniques such as SBRT as the primary treatment for painful spine bone lesions or for spinal cord compression should be considered in the setting of a clinical trial or with data collected in a registry given that insufficient data are available to routinely support this treatment currently."

### **Repeat Treatment**

Following initial treatment with radiation therapy for bony metastasis, some patients will develop recurrent or progressive symptoms for which additional radiation therapy is indicated. Studies have shown repeat radiation therapy to be effective in reducing pain in approximately 48% of patients. Responders have been shown to have improved quality of life. When a given site is re-treated, the effect of prior irradiation on the surrounding normal tissues must be taken into account. This is especially important when treating vertebral lesions where to cumulative dose to the spinal cord must be minimized. The generally accepted maximum cumulative dose to the spinal cord is 50 Gy in 2 Gy fractions (or equivalent). If repeat radiation using 2D or 3D techniques would result in a cumulative dose to the spinal cord greater than 50 Gy in 2 Gy fractions then consideration should be given to intensity modulated radiation therapy (IMRT), SRS, or SBRT.

### **Central Nervous System (CNS) Cancers (Intracranial, Spinal, Ocular and Neurologic)**

Brain metastasis is the most common CNS malignancy. Patients with brain metastasis have a poor prognosis, with a median survival of 2-3 months when treated with steroids alone. The addition of whole brain radiation therapy (WBRT) generally extends median survival to 3-6 months. Individual results vary significantly based on the number of metastatic lesions, the performance status of the patient and the extent of extracranial disease. In recent years, there has been a trend away from the use of WBRT in patients with limited disease who are candidates for surgery or radiosurgery in order to minimize the neurocognitive complications of WBRT. WBRT with standard 2D or 3D conformal radiation therapy is recommended for individuals with multiple brain metastases (greater than 4 treated in a given session), and should also be considered in individuals with brain metastases and any of the following: ECOG performance status greater than 2, presence of progressive and symptomatic visceral disease, or metastases significantly progressing after multiple treatment options. The RTOG has studied several different fractionation schedules for WBRT and prolonged fractionation schedules did not improve outcomes compared to 30 Gy in 10 fractions.

Historically, surgical resection has been performed in patients with solitary metastasis in accessible locations. Postoperative WBRT has been shown to reduce the risk of recurrence in a randomized trial. For brain metastases greater than 4 cm in diameter or causing mass effect, surgery is preferred over SRS.

External beam radiation treatment is a common treatment for primary brain tumors as either definitive or adjuvant therapy after resection. For high grade gliomas, concurrent temozolomide chemotherapy is

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

generally recommended as it has been shown to increase survival compared to radiotherapy alone. In 2016, ASTRO published an evidence-based clinical practice guideline on radiation therapy for glioblastoma. For patients with reasonable performance status up to age 70, a dose of 60 Gy in 30 fractions should be given. For elderly patients, hypofractionated treatment such as 40 Gy in 15 fractions gives similar results. IMRT may provide better coverage for primary brain lesions, with decreased exposure of normal brain tissue. IMRT is recommended when a lesion is in close proximity to a critical or sensitive structure and 3D conformal radiation would result in unsafe exposure to these structures. The use of IMRT for hippocampal sparing is under active investigation and should only be used in the context of a clinical trial. IMRT is considered medically necessary in any case of repeat irradiation of overlapping or bordering treatment fields.

SRS has an excellent safety profile for many clinical situations when targets are localized, and it has applications for both benign and malignant lesions. It also often represents an alternative to surgical intervention when patients are not optimal surgical candidates. SRS has been extensively studied in the treatment of limited brain metastases. Control rates of approximately 90% are reported. Although recurrence elsewhere in the brain is common, the addition of WBRT to SRS does not improve survival. This has led to the ASTRO Choosing Wisely recommendation not to routinely add WBRT to SRS for limited brain metastasis. SRS is not recommended for the treatment of CNS lymphoma.

Stereotactic boost for high grade gliomas has been studied in several randomized controlled clinical trials. RTOG 93-05 randomized patients with glioblastoma multiforme to upfront SRS followed by conventional radiotherapy and carmustine to the same treatment without SRS. With a median follow-up of 61 months, there was no difference in survival, pattern of failure or quality of life in the two groups. RTOG 0023 studied the use of a stereotactic conformal boost for supratentorial glioblastoma multiforme. In this study, four weekly stereotactic boost treatments were delivered to give a cumulative dose of 70-78 Gy to the postoperative enhancing tumor. There was no difference in survival compared to historical controls. Based on these studies, SRS or SBRT are considered investigational for the primary treatment of grade 3-4 gliomas.

For certain benign CNS abnormalities, SRS has been shown to be a safe and effective treatment. Soon after the development of the Gamma Knife<sup>®</sup> by Leksell in the 1970s, it was studied for the treatment of AVM where it has been shown to have an 80% obliteration rate. Based on this proof of concept, SRS has subsequently been shown to be an effective alternative to surgery for a wide variety of benign lesions including ocular melanoma, retinoblastoma, schwannoma, craniopharyngioma, pineal lesions and pituitary adenoma. SRS for the treatment of trigeminal neuralgia is medically necessary in cases refractory to medical management. SRS for the treatment of epilepsy, Parkinson's disease and other movement disorders is listed as "insufficient evidence" in an evidence-based review by the American Academy of Neurology and therefore remains investigational at this time.

SRS is given as a single fraction. Cranial stereotactic treatment given in 2-5 fractions is billed as SBRT.

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

For metastatic lesions outside the brain, please refer to specific guidelines for the appropriate location (e.g., Lung Cancer for lung metastases).

### **Colorectal and Anal Cancers**

#### **Anal Cancer**

Cancer of the anal region are relatively rare, accounting for less than 3% of all digestive system cancers. They are almost always squamous cell carcinomas and are frequently associated with Human papilloma virus (HPV) infection. Because of the lymphatic drainage of this area, the inguinal lymph nodes are at risk and are commonly involved when lesions involve the area below the dentate line. Although these cancers have been treated with abdominoperineal resection in the past, the current standard of care is concomitant chemoradiotherapy with a fluoropyrimidine and either mitomycin or cisplatin. Doses of 45 Gy are given for early stage tumors. More advanced and node positive cancers are treated to doses of 54-59.4 Gy. IMRT techniques, which can reduce the toxicity associated with radiation, are preferred over 3D conformal techniques for the treatment of anal cancer and cancers of the anal canal. The radiation field includes the pelvis, the anus, the perineum, and the inguinal lymph nodes. Definitive treatment of anal cancers typically involves concurrent radiation and chemotherapy.

Palliative radiation with 3D conformal techniques is recommended for metastatic disease or to enhance local control of a symptomatic bulky primary.

#### **Rectal Cancer**

CRC is much more common than anal cancer and is the second most common cause of cancer death. Rectal cancers, which occur below the peritoneal reflection, benefit from radiation therapy which has been shown to reduce local recurrence and improve survival. Radiation is generally given with 5-fluorouracil or capecitabine chemotherapy. Preoperative chemoradiation is preferable because it is better tolerated and improves the chance of sphincter sparing surgery in marginally resectable patients. Treatment with 3D conformal radiation is recommended. IMRT should only be used as part of a clinical trial, when inguinal nodes are being treated or when 3D treatment would result in unsafe doses being delivered to normal tissues. The radiation field should include the presacral nodes, internal iliac nodes, and external iliac nodes for T4 tumors. Typically, 45 Gy is given to the initial field with an additional 5.4 – 9 Gy being given to a cone down boost field. Short-course preoperative radiotherapy to a dose of 25 Gy is another alternative.

#### **Colon Cancer**

Radiation is not a standard part of local treatment for colon cancer, but is incorporated into treatment for selected patients. It is generally used in situations where there is an elevated risk of local recurrence due to local invasion of the surrounding tissues. 3D conformal radiation is the standard option, and IMRT is reserved for repeat irradiation of previously treated patients.

Stereotactic radiation techniques have been considered in highly selected cases of limited hepatic metastases; however, surgical resection is the standard of care. Please see the section on hepatobiliary cancers for more guidance on the treatment of liver metastases.

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

For review of metastatic sites, please refer to specific guidelines for the appropriate location. (e.g., CNS Cancers for brain metastases, Lung Cancer for lung metastases)

### **Gastrointestinal Cancers, Non-Colorectal (Cholangiocarcinoma, Esophageal, Gastric, Liver and Pancreatic)**

#### **Esophageal Cancer**

Esophageal cancers can be histologically classified as squamous cell carcinoma or adenocarcinoma. Squamous cancers are more common in the cervical and mid-thoracic esophagus while adenocarcinomas are more common in the distal esophagus and gastroesophageal junction. The latter are more common in Western countries and are associated with gastroesophageal reflux and Barrett's esophagus. Radiation therapy is a common part of the multidisciplinary treatment of esophageal cancers. Radiation can be used pre-operatively, post-operatively, as primary therapy in conjunction with chemotherapy or as a palliative modality to improve swallowing. Long-term results of the CROSS randomized controlled trial of neoadjuvant chemoradiation followed by surgery showed improved survival compared to surgery alone. Radiation in that study was given with 3D-conformal techniques. IMRT is still under active investigation for treatment of esophageal cancer. Retrospective comparisons have not demonstrated improved survival but have shown a decrease in grade 3 toxicities such as hospitalization, feeding tube placement and >20% weight loss. IMRT should only be used in curative cases where 3D-conformal planning shows unacceptable doses to surrounding structures including the heart, lungs, spinal cord or small bowel. In these cases, a documented 3D-conformal plan may be requested for review.

#### **Gastric Cancer**

Gastric cancer is relatively uncommon in the United States but is a common cause of cancer and cancer mortality worldwide. It is associated with Helicobacter pylori infection, smoking and heavy drinking. Gastric cancer frequently presents at an advanced stage. Chemoradiation has an established role in the adjuvant treatment of resected tumors based on the results of intergroup study 0116. Patients in that randomized study who received chemoradiation had improved survival compared to patients treated with surgery alone. Use of 3D treatment planning is recommended. Treatment recommendations depend on the location of the bulk of the tumor, location and lymph node involvement. In addition to adjuvant post-operative treatment, radiation is used in a variety of clinical situations, including pre-operative treatment, in combination with chemotherapy, and as a palliative therapy. Significant supportive care is required during a full course of treatment. No prospective studies of IMRT in gastric cancer have been published. Several institutions have noted improved dose distribution and better organ sparing with IMRT for stomach cancer. No survival advantage with IMRT has been reported.

#### **Hepatobiliary Cancer**

HCC and cholangiocarcinomas of the gallbladder, intrahepatic and extrahepatic bile ducts are relatively rare but lethal cancers of the liver and bile ducts. HCC is commonly associated with cirrhosis due to hepatitis and other factors. Although there are no prospective data on the use of IMRT for the treatment of these cancers, the liver is very sensitive to radiation therapy and IMRT may have a limited role in the treatment of HCC and cholangiocarcinoma when 3D-conformal therapy would result in unacceptable toxicity due to exposure of the liver and other surrounding normal tissues. There is growing literature support for the use of

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

SBRT as a local treatment option for hepatocellular cancer. This technology remains under active investigation in many clinical situations, and more data is needed to clarify the role of SBRT. Patients should first be evaluated for potential curative therapy, such as resection, radiofrequency ablation (RFA), transcatheter arterial chemoembolization (TACE) or transplantation.

Selective Internal Radiation Therapy (SIRT) is also known as radioembolization. This technique targets the delivery of small beads or microspheres containing yttrium-90 to the tumor. It is used for palliation of liver tumors, and is sometimes used as a bridge to liver transplantation.

### **Liver Metastases**

The use of stereotactic techniques to treat liver metastases is the subject of clinical trials. Small trials have addressed this issue, but long term survival and quality of life remain unclear.

### **Pancreatic Cancer**

For the treatment of pancreatic cancer, radiation is recommended in the setting of unresectable or borderline resectable disease (neoadjuvant or definitive), adjuvant treatment after surgery, and palliation of symptoms. Outside of palliative care, radiation is traditionally administered concurrently with chemotherapy. There is no clear standard for neoadjuvant therapy, and multiple chemoradiotherapy options are available. 3D conformal radiation techniques are considered standard. A recent systematic review by Bittner compares outcomes and toxicity in patients treated with IMRT and 3D-conformal radiotherapy for pancreatic adenocarcinoma. There were no apparent differences in overall or progression free survival. Both nausea/vomiting and diarrhea were statistically lower with IMRT compared to 3D-conformal, although the differences were modest (7.8% vs. 13% and 2% vs. 11.6% respectively,  $p < 0.001$  for both). Long term grade 3 or greater GI toxicity was 5% with IMRT vs. 10.6% with 3D ( $p = 0.017$ ). Given the lack of improved outcomes, IMRT should only be used in curative cases where 3D-conformal planning would result in unacceptable doses to surrounding normal tissues. Care should be taken to adhere to recommended target coverage and dose specifications as radiation quality has been shown to impact survival in several studies. SBRT studies suggest good local control but at the expense of significant toxicity. Further studies with stereotactic techniques and IMRT for hypofractionation protocols are ongoing. IMRT is not well established for the treatment of pancreatic cancer.

For review of other metastatic sites, please refer to specific guidelines for the appropriate location. (e.g. CNS for brain metastases, Lung for lung metastases)

### **Genitourinary Cancers (Bladder, Penile, and Testicular)**

#### **Bladder Cancer**

Bladder cancers arise in the transitional urothelium which lines the urinary bladder. About two-thirds of these do not invade the muscle layer at the time of diagnosis and are treated with transurethral resection (TURBT) with or without instillation of an intravesicle adjuvant therapy such as *Bacillus Calmette-Guérin* (BCG), mitomycin or gemcitabine. Muscle invasive cancer requires more aggressive treatment. The standard of care is radical cystectomy. Postoperative radiotherapy is indicated for T3 or T4 tumors and when there is involvement of the pelvic lymphatics. Bladder preservation therapy with concurrent chemoradiotherapy is an alternative for highly motivated patients after maximal TURBT and results in 60-

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

80% rates of functional bladder sparing. In the palliative setting, radiation alone is an effective treatment for hematuria. For definitive therapy, it is recommended to treat the whole bladder to 40-45 Gy followed by a boost to the bladder tumor to a total dose up to 66 Gy excluding, if possible, normal areas of the bladder from the boost volume. When high doses of radiotherapy are given, IMRT is often indicated to minimize the dose to pelvic organs at risk, especially the small bowel.

### **Penile Cancer**

Penile cancer is rare and requires multidisciplinary management. Brachytherapy is the preferred approach in selected cases of early stage penile cancers. Concurrent chemoradiotherapy as primary treatment, or after surgery is recommended for larger tumors and when there is nodal involvement. Radiation may also be used when surgical margins are positive.

### **Testicular Cancer**

Following inguinal orchiectomy for early stage pure seminoma, there is an approximately 15% risk of recurrence in the para-aortic lymph nodes. External beam radiation significantly reduces this risk and is an option to surveillance or single agent chemotherapy in stage I disease. Radiation to the para-aortic and ipsilateral iliac nodes is an alternative to chemotherapy in individuals with stage IIA and IIB disease. IMRT is not recommended for treatment of pure testicular seminomas due to the low doses given and the increased risk of secondary malignancy in the kidney, liver, or bowel with IMRT. Radiation is not a standard component in the treatment of non-seminomatous testicular cancer.

For review of metastatic sites, please refer to specific guidelines for the appropriate location. (e.g. CNS for brain metastases, Lung for lung metastases)

### **Gynecologic Cancers (Cervical, Fallopian Tube, Ovarian, Uterine, and Vulvar/Vaginal)**

Brachytherapy is considered standard of care in the treatment of many GYN malignancies, and both high dose rate (HDR) and low dose rate (LDR) brachytherapy treatments are used.

External beam radiation is used in many clinical situations to treat pelvic tissues and regional lymph nodes. With significant toxicity constraints, particularly GI and urologic toxicity, IMRT is often the recommended modality.

IMRT is not routinely recommended for palliative treatment of symptoms in the setting of advanced disease.

### **Cervical Cancer**

In the United States, cervical cancer is relatively uncommon. About 80% of cases are squamous cell carcinoma. HPV infection is known to increase the risk of cervical cancer and this had led to development of a vaccine to prevent the disease. Early stage cervical cancer can be treated with either surgery or radiation. More advanced disease is treated with concurrent chemoradiotherapy followed by brachytherapy. If high risk features are found at the time of surgery, adjuvant postoperative radiotherapy is indicated. IMRT is helpful in minimizing radiation dosage to the critical structures in the pelvis, particularly the bowel.

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

Compared to 3D conformal radiotherapy, IMRT has been shown to reduce the incidence of acute and chronic gastrointestinal side effects and also lower the risk of bowel obstruction.

External beam radiation techniques should not be considered alternatives to brachytherapy for an intact cervix.

Brachytherapy is commonly incorporated into the definitive management of cervical cancer. For treatment of the intact cervix, tandem and ovoid or tandem and ring applicators are most often used. For more advanced cases, interstitial implants may be required. Brachytherapy can be delivered with either LDR or HDR techniques. When LDR brachytherapy is used, two applications are typically performed. For HDR treatment, up to six fractions are appropriate. Brachytherapy can be used alone for very early stage cervical cancer. More commonly, brachytherapy is used as a boost following external beam radiotherapy. When tumors are not adequately dosed with brachytherapy, completion hysterectomy may be of benefit. Concurrent platinum based chemotherapy has been shown to improve survival compared to radiotherapy alone for early stage high risk disease as well as advanced stage disease.

### **Uterine Neoplasms**

Endometrial cancers arise in the uterine lining and commonly present as post-menopausal bleeding. They are more common than cervical cancer with approximately 55,000 cases per year. The primary treatment for endometrial cancer is surgery. Primary radiation can be used in patients who are not surgical candidates. Adjuvant radiation therapy has been shown to decrease recurrences in women at risk. Risk factors for recurrence include age, depth of myometrial invasion, tumor grade and presence of lymphovascular invasion. Most recurrences are in the vaginal cuff. EBRT targets any gross disease present, the parametrial regions, upper vaginal and paravaginal tissues, as well as pelvic lymph nodes (lower common iliac, external iliac, internal iliac, presacral). IMRT techniques reduce the radiation dose to nearby critical pelvic structures, such as small bowel. External pelvic radiotherapy is the preferred treatment for stage IB grade 3 lesions and patients with involved nodes. A brachytherapy boost is appropriate for patients with endocervical or cervical stromal involvement. Whether external radiotherapy can be replaced by vaginal brachytherapy and chemotherapy for high risk stage I and stage II patients is currently being studied by the Gynecologic Oncology Group (GOG). Vaginal brachytherapy alone is preferred for most other stage I patients based on the results of the PORTEC-2 randomized trial, although EBRT may be reasonable for those at especially high risk of locoregional recurrence (LRR). As advocated in the 2014 Choosing Wisely campaign, stage IA patients with grade 1 or 2 disease and no other risk factors should be observed.

Uterine sarcomas are rare tumors arising in muscle or connective tissue. Postoperative radiation therapy is recommended for patients at high risk for pelvic recurrence after surgery. As with other GYN cancers, IMRT may be used to reduce the dose to the small bowel.

### **Ovarian Cancer**

Radiation therapy is no longer a common component of initial treatment or consolidative therapy for primary epithelial ovarian cancer treatment. Standard of care includes surgical resection or debulking and systemic

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.





# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

chemotherapy. Palliative radiation remains an option to manage symptoms in recurrent or metastatic disease.

For review of metastatic sites, please refer to specific guidelines for the appropriate location (e.g., CNS Cancers for brain metastases and Lung Cancer for lung metastases).

### **Head and Neck Cancers including Thyroid Cancer**

Head and Neck Cancers are defined as cancers of the lip, oral cavity, oropharynx, hypopharynx, nasopharynx, glottic larynx, supraglottic larynx, ethmoid and maxillary sinus, nasal cavity, salivary glands (including Parotid), Mucosal Melanoma, and Head and Neck occult primary. This category does not include other tumor types that arise in the Head and Neck region, such as lymphoma.

IMRT has demonstrated improvement for Head and Neck cancer irradiation by reducing long-term side effects in the oropharyngeal, paranasal sinus, and nasopharyngeal cancers by reducing the dose to salivary glands, temporal lobes, auditory and optic structures. The use of IMRT to other regions has similar benefits and may be administered at the discretion of the ordering physician. However, the use of IMRT for early stage (stages I, II) laryngeal cancer has not been well established.

Differentiated thyroid cancers are most often treated with surgical resection, with or without radioactive iodine (RAI). External beam radiation is used in a variety of clinical situations, including inadequate RAI uptake, unresectable or incompletely resected disease, LRR, and metastatic disease. IMRT and SBRT have not been accepted as a standard in these settings, and should be reserved for treatment of a previously irradiated field.

Anaplastic thyroid cancer represents a highly lethal malignancy, with no clearly effective treatment protocols. External beam radiation, with or without chemotherapy, may improve short-term survival, and can be used to palliate symptoms, particularly airway obstruction. IMRT techniques have been shown to reduce toxicity.

For review of metastatic sites, please refer to specific guidelines for the appropriate location (e.g., CNS for brain metastases, Lung for lung metastases)

### **Lung Cancer, Small Cell and Non-Small Cell**

Radiation therapy has a potential role for the treatment of lung cancers in all stages of disease.

For NSCLC, radiation may be used as an adjunct to surgery. It may also serve as definitive therapy in unresectable disease. For unresectable stage II and III disease, concurrent chemoradiotherapy is considered standard of care, when tolerated. 3D conformal radiation typically provides optimal coverage of tumor volumes. IMRT may improve dose-volume constraints, but at the expense of increasing the volume of normal tissue exposed to low doses of radiation.

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

The optimal dose and fractionation for both definitive and palliative treatment of NSCLC has been the subject of numerous clinical investigations. Based on several earlier phase I/II trials of dose escalation, RTOG 0617 compared standard-dose (60 Gy) with high-dose (74 Gy) conformal radiotherapy given concurrently with carboplatin and paclitaxel chemotherapy with and without the addition of cetuximab. There was no benefit from the use of cetuximab in either arm. Overall survival was better in the standard-dose arms (28.7 vs 20.3 mos,  $p < 0.004$ ). Standard-dose radiotherapy also resulted in better median progression free survival (11.8 vs 9.8 mos), lower risk of severe esophagitis (7% vs 21%,  $p < 0.0001$ ) and fewer treatment related deaths. ASTRO recently published an evidence-based clinical practice guideline which concluded that the ideal external beam dose fractionation for curative intent chemoradiotherapy for NSCLC is 60 Gy given in 2 Gy once daily fractions over 6 weeks. Dose escalation beyond 60 Gy was not recommended outside the setting of clinical trial. This guideline has also been endorsed by ASCO. When used without concurrent chemotherapy, the guideline recommends a minimum dose of 60 Gy.

In metastatic NSCLC where palliative treatment is being considered, the goal is to strike a balance between symptom relief, local control and treatment toxicity. ASTRO published a comprehensive evidence based guideline on palliative radiotherapy in lung cancer. The guideline concluded that higher-dose/fractionation regimens (30-Gy/10-fraction or higher) may benefit patients with good performance status. These higher dose regimens are associated with significant adverse effects such as esophagitis. Shorter course treatment is recommended for patients with poor performance status. Treatment with concurrent chemotherapy was not supported. Despite this recommendation, Koshy et al found that almost half of stage IV lung cancer patients received inappropriately high doses of radiation (defined as more than 15 fractions).

Stereotactic radiation may be used as definitive therapy in earlier stages of disease for patients who may not be candidates for invasive surgery. Furthermore, stereotactic radiation may be recommended for local palliation or prevention of symptoms such as hemoptysis, obstruction, or pain.

Radiation therapy is also used in all stages of small cell lung cancer, either as definitive treatment in combination with chemotherapy, or as palliative therapy. Concurrent chemotherapy is preferred to sequential chemotherapy with RT. Target volumes are best defined with pre-treatment positron emission tomography/computed tomography (PET/CT) obtained at the time of radiotherapy planning. Consolidative thoracic radiation may be beneficial to select patients with extensive stage disease who have significant responses to standard chemotherapy.

The utility of 2D radiation is likely limited to palliative treatment of metastatic disease.

The minimum standard used to treat intrapulmonary lesions is 3D conformal, with CT planning. PET/CT is noted to significantly improve targeting accuracy. Tumor motion should be accounted for.

The clinically appropriate use of more advanced modalities, such as IMRT and SBRT, are limited to specific clinical scenarios. It is the responsibility of the Radiation practice to create optimal treatment plans when evaluating modality choices for treatment.

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

For review of metastatic sites, please refer to specific guidelines for the appropriate location (e.g., CNS Cancers for brain metastases and Lung Cancer for lung metastases).

### **Lymphoma: Hodgkin and Non-Hodgkin**

#### **Hodgkin Lymphoma**

Hodgkin lymphoma is a malignancy of the lymphatic system with distinct clinical and pathologic features which set it apart from Non-Hodgkin lymphoma. The disease commonly affects lymph nodes in the mediastinum but can affect nodes and other lymphatic organs throughout the body. Occasionally, the bone marrow and liver are also involved. Pathologically, Hodgkin lymphoma is characterized by the presence of characteristic lymphocytes called Reed-Sternberg cells.

There are four distinct subtypes of Hodgkin lymphoma. About 80% of cases are termed nodular sclerosing Hodgkin lymphoma. The other types include lymphocyte-predominant, mixed cellularity and lymphocyte-depleted Hodgkin lymphoma. Over the years, treatment has evolved from radiotherapy or chemotherapy alone to a risk adapted approach of chemotherapy and involved site radiotherapy. Treatment intensity is also guided by treatment response on PET scan performed after multiple cycles of chemotherapy.

For favorable stage I and II disease, 20-30 Gy of involved site radiotherapy is given after chemotherapy. For bulky disease at presentation, doses of 30-36 Gy are appropriate. Although these doses are generally below the dose tolerance of the surrounding normal tissues, there are situations where advanced planning techniques are likely to result in a meaningful decrease in late toxicity from radiotherapy. Koeck et al. published a planning comparison of 3D versus IMRT for patients with unfavorable mediastinal Hodgkin lymphoma and found reduced mean heart and spinal cord doses with IMRT. Doses to the lungs and breasts were higher with 3D conformal radiation. The most pronounced benefits were seen in patients with lymph nodes anterior to the heart. Since IMRT has been shown to increase low dose exposure to the breasts and lungs, the potential benefit of cardiac sparing needs to be weighed against increased risks of breast and lung cancer, especially in female patients. The role of IMRT in the treatment of non-mediastinal Hodgkin lymphoma has not been studied and therefore IMRT in these cases is considered not medically necessary.

#### **Non-Hodgkin Lymphoma (NHL)**

Non-Hodgkin Lymphoma is a cancer arising in lymphocytes and includes all subtypes except Hodgkin Lymphoma (described below). The disease most commonly involved B-cells but can involve other types of lymphocytes. Historically, lymphomas have been grouped based on histology into low grade, intermediate grade and high grade. Advances in tumor phenotyping have allowed more sophisticated subtyping to guide treatment.

Specific treatment depends on the grade and extent of disease. Treatments may include chemotherapy, immunotherapy or other targeted therapy, radiation therapy and stem cell transplantation. Some asymptomatic follicular (low grade) lymphomas may not require active treatment. In other cases, involved site radiotherapy alone or in combination with systemic therapy is used. Doses range from 20-36 Gy. Stage I and II diffuse large B-cell lymphoma is typically treated with combined chemotherapy and radiotherapy. The dose to the involved site is guided by the response to 3-6 cycles of R-CHOP chemotherapy (regimen of

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

cyclophosphamide, doxorubicin, vincristine, and prednisone). Doses of 30-36 Gy are given to consolidate complete responses while doses of 40-50 Gy are used to treat partial responses. Radiotherapy is also applied to bulky sites of involvement after chemotherapy in stage III and IV lymphoma. Lymphoma including mucosal associated (MALT) lymphomas, mantle cell lymphoma, Burkitt's lymphoma and others may involve radiotherapy with doses up to 45 Gy as part of the treatment.

Because the doses of radiation needed for non-Hodgkin lymphoma are lower than doses used for most other types of cancer, the need for advanced planning techniques such as IMRT is limited. As with Hodgkin lymphoma, IMRT is appropriate for mediastinal disease due to the proximity of the target to sensitive normal structures. For other sites, there are limited data regarding IMRT and therefore it is considered not medically necessary.

### **Other tumor types, including Sarcoma, Thymoma and Thymic Carcinoma, Pediatric Tumors and other malignancies**

#### **Sarcomas**

Soft tissue sarcomas are rare malignancies arising in connective tissue. Multimodality treatment with surgery, radiation and chemotherapy is common, especially in high grade sarcomas. Multiple studies have shown that radiation improves local control. Soft tissue sarcomas are often treated with preoperative therapy to a dose of 50 Gy. Placement of clips at the time of surgery aids with boost planning if needed. Alternatively, postoperative radiation therapy can be given. External beam treatment typically consists of 50 Gy to a larger field encompassing the preoperative tumor volume plus a margin followed by a smaller boost field. Boost doses of 10-26 Gy are used, depending on the final surgical margins. Brachytherapy may also be used postoperatively, particularly in the setting of microscopic or gross residual disease after resection. Alternatively, intra-operative radiation may be considered as boost treatment at the time of surgery.

In terms of radiation planning, the use of MRI imaging and CT based planning are recommended. IMRT is sometimes utilized, but is particularly helpful in the setting of pelvic or retroperitoneal sarcoma, to minimize toxicity in this high-risk anatomic region. IMRT for sarcomas in other regions remains an area of active investigation. A recent RTOG study of image guidance suggested that toxicity is lower when field size is reduced in conjunction with daily IGRT. Many of these patients were treated with IMRT, but is unclear whether the reduction in toxicity is due to IMRT or margin reduction. Other retrospective comparisons of conventional radiation and IMRT have been published. A study by Folkert reported recurrence rates for 319 consecutive patients, about half of whom were treated with IMRT. There was an association between use of IMRT and improved local control. The authors note, however, that other confounding factors such as the use of MRI in treatment planning may explain the difference. The use of IMRT for soft tissue sarcomas is appropriate when conventional treatment would result in unacceptable toxicity.

#### **Thymoma and Thymic Carcinoma**

Thymomas are rare tumors arising in epithelial cells within the thymus. They can be benign or malignant. For lesions which are resectable, complete thymectomy and excision of tumor is recommended. Radiotherapy is added for stage III disease or in cases where the tumor is unresectable or incompletely resected. Doses of 45-50 Gy are used after resection with clear or close margins. A dose of 54 Gy is used

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

for microscopically positive margins and doses of 60-70 Gy are given for gross disease. Chemotherapy is used in advanced or metastatic disease. CT-based treatment planning is recommended, as is respiratory motion management if available. Much like mediastinal Hodgkin lymphoma, IMRT is appropriate in order to spare heart and lung tissue.

### **Pediatric Tumor Types**

IMRT is a method to spare normal tissue from radiation damage, and reduce the risk of toxicity, complications, and secondary malignancy in normal tissues that are still developing. IMRT has demonstrated excellent potential in sparing the organs at risk while achieving good local control. Therefore, IMRT is helpful in treating pediatric tumors that are sensitive to radiation therapy. Please see proton beam guidelines for further details regarding use of protons in pediatric tumors.

### **Other Tumor Types**

IMRT and stereotactic radiation techniques are used in the setting of overlapping with a previously irradiated field, due to the risk of toxicity or complications.

For review of metastatic sites, please refer to specific guidelines for the appropriate location (e.g., CNS Cancers for brain metastases and Lung Cancer for lung metastases).

### **Prostate Cancer**

Prostate cancer is the most common cancer seen in men. Early detection has resulted in a decrease in prostate cancer mortality over the past two decades.

Active surveillance options should be discussed with individuals with low risk prostate cancers. Furthermore, individuals with low- or intermediate-risk prostate cancer and an anticipated survival of less than 10 years based on comorbidity are recommended to be followed with observation, as the risk of over-treatment may outweigh the clinical benefit.

External beam radiotherapy and surgery are the primary treatment modalities in patients who do not opt for surveillance. Improvement in radiation therapy delivery, including 3D-conformal radiation and IMRT, have allowed for the safe dose escalation which has improved cure rates in patients with localized disease. There is a trend toward hypofractionation (fewer treatments to deliver the same biologic dose) which allows patients to be treated with less disruption of their daily lives. This trend is expected to continue over time.

Pelvic nodal irradiation should be limited to individuals with intermediate-risk or high-risk disease.

When adjuvant radiation therapy is indicated, it should be given within 1 year of radical prostatectomy, but after any post-operative issues have stabilized. SBRT for prostate cancer is an emerging modality. This technology delivers a high biologic dose of radiation over a short period of time. The hypofraction associated with SBRT shortens the treatment time to five visits, compared to the 7 to 9 weeks typically required for IMRT. This shortened treatment time is (one week vs. 8-9 weeks) is appreciated by individuals. The key outcomes include both tumor control and toxicity, primarily focusing on acute and chronic rectal and

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

genitourinary complications. While there have been no controlled studies directly comparing SBRT and alternative techniques of conformal therapy (for example, IMRT) many prospective case series and retrospective cohort studies of subjects with localized low-risk and intermediate-risk prostate cancer and prolonged life expectancies have consistently reported that SBRT is associated with an acceptable toxicity profile and tumor control that is comparable to other radiation techniques. As with other treatments for prostate cancer, it is unlikely that randomized comparisons will be performed. Published studies to date include single institution reports, multi-institutional phase I/II studies looking at dose and systematic reviews. Hannan has recently published five year results of a prospective phase I/II trial of SBRT in 91 low-risk to intermediate-risk patients. About two-thirds of the patients had intermediate risk disease. Doses of 45-50 Gy in five fractions were given. The five year freedom from biochemical failure was 98.6%. Grade 3 or greater late urinary and GI toxicities were 5.5% and 7% respectively. The highest rates of toxicity were seen in the 50 Gy cohort and the authors recommend against this dose. At the lower doses, toxicities are similar to that seen in dose-escalated IMRT. The most recent systematic review of SBRT for prostate cancer looked at 1,472 patients in 14 studies. The most common fractionation ranged from 35-36.25 Gy in five fractions. Most of these reports were for patients treated with Cyberknife<sup>®</sup>. Biochemical progression free survival ranged from 81-100%. Acute and late grade 3 urinary and GI toxicities ranged from 0-0.5% (acute) to 0.5-1.3% (late). In May, 2013, ASTRO updated its Model Policy for SBRT and states "It is ASTRO's opinion that data supporting the use of SBRT for prostate cancer have matured to a point where SBRT could be considered an appropriate alternative for select patients with low to intermediate risk disease."

There has been no demonstration to the superiority of proton beam radiation therapy (PBRT) over other radiation modalities for the treatment of prostate cancer, and should not be used outside the setting of a clinical trial.

### **FDA or Other Governmental Regulatory Approval**

U.S. Food and Drug Administration (FDA)

Several devices that use cobalt 60 radiation (gamma ray devices) for SRS have been cleared for marketing by FDA through the 510(k) process. The most commonly used gamma ray device is the Gamma Knife (Elekta, Stockholm; approved May 1999; product code IWB), which is a fixed device used only for intracranial lesions. Gamma ray emitting devices that use cobalt 60 degradation are also regulated through the U.S. Nuclear Regulatory Commission.

A number of linear accelerator (LINAC) movable platforms that generate high-energy photons have been cleared for marketing by FDA through the 510(k) premarket notification process. Examples include the Novalis Tx<sup>®</sup> (Novalis, Westchester, IL); the TrueBeam STx (Varian Medical Systems, Palo Alto, CA; approved December 2012; product code IYE); and the CyberKnife Robotic Radiosurgery System (Accuray, Sunnyvale, CA; approved December 1998; product code MUJ). LINAC-based devices may be used for intracranial and extracranial lesions.

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

Centers for Medicare and Medicaid Services (CMS)

There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

### Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. FDA approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, Blue Cross and Blue Shield Association technology assessment program (TEC) and other non-affiliated technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

### References

1. AIM Specialty Health, AIM Guidelines for Image Guidance in Radiation Oncology, November 1, 2017. Last Reviewed June 13, 2017.
2. Blue Cross and Blue Shield Association, Medical Policy Reference Manual, "Stereotactic Radiosurgery and Stereotactic Body Radiotherapy", 6.01.10, 8:2015.
3. ECOG-ACRIN Cancer Research Group, ECOG Performance Status; 2016. <http://ecog-acrin.org/resources/ecog-performance-status>.
4. Oken M, Creech R, Tormey D, et al. Toxicity and response criteria of the Eastern Cooperative Oncology Group. *Am J Clin Oncol*. 1982;5:649-655.
5. Karnofsky D, Burchenal J, The clinical evaluation of chemotherapeutic agents in cancer. In: MacLeod C, ed. *Evaluation of Chemotherapeutic Agents*. New York, NY: Columbia University Press; 1949:191–205.
6. Zubrod C, et al. Appraisal of methods for the study of chemotherapy in man: Comparative therapeutic trial of nitrogen mustard and thiophosphoramide. *Journal of Chronic Diseases*; 1960:11:7-33.

### Policy History

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

03/21/2002	Medical Policy Committee review
03/25/2002	Managed Care Advisory Council approval
06/24/2002	Format revision
03/08/2004	Medical Director review
03/16/2004	Medical Policy Committee review. Format revision. No substance change to policy statement.
03/29/2004	Managed Care Advisory Council approval
03/01/2005	Medical Director review
04/27/2005	Medical Policy Committee review. Patient selection criteria changes address clinical parameters for use of stereotactic radiosurgery in the presence of three or fewer and greater than three lesions.
05/23/2005	Managed Care Advisory Council approval
07/07/2006	Format revision, including addition of FDA and or other governmental regulatory approval and rationale/source. Coverage eligibility unchanged.
08/02/2006	Medical Director review
08/09/2006	Medical Policy Committee approval. Background, rationale/source and references updated.
09/05/2007	Medical Director review
09/19/2007	Medical Policy Committee approval. No change to coverage eligibility.
06/04/2008	Medical Director review
06/18/2008	Medical Policy Committee approval. Extracranial sites now eligible for coverage with criteria.

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.



# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

06/04/2009	Medical Director review
06/17/2009	Medical Policy Committee approval. Title changed to track BCBSA.
06/03/2010	Medical Policy Committee review
06/16/2010	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
06/02/2011	Medical Policy Committee review
06/15/2011	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
02/02/2012	Medical Policy Committee review
02/15/2012	Medical Policy Implementation Committee approval. Criteria revised to include inoperable non-small cell lung cancer or pulmonary metastases and liver malignancy.
01/03/2013	Medical Policy Committee review
01/09/2013	Medical Policy Implementation Committee approval. Craniopharyngiomas and Glomus jugulare tumors were added to the cranial site criteria. Spinal or vertebral metastases that are radioresistant (e.g., renal cell carcinoma, melanoma and sarcoma was added to the extracranial site criteria.
01/09/2014	Medical Policy Committee review
01/15/2014	Medical Policy Implementation Committee approval. No change to coverage.
06/04/2015	Medical Policy Committee review
06/17/2015	Medical Policy Implementation Committee approval. Added uveal melanoma and tremors to INV indications. Title change. Updated rationale and references.
08/03/2015	Coding update: ICD10 Diagnosis code section added; ICD9 Procedure code section removed.
02/04/2016	Medical Policy Committee review
02/17/2016	Medical Policy Implementation Committee approval. Updated patient selection criteria for Extracranial.
11/01/2016	Coding update
01/01/2017	Coding update: Removing ICD-9 Diagnosis Codes
02/02/2017	Medical Policy Committee review
02/15/2017	Medical Policy Implementation Committee approval. No change to coverage.
09/07/2017	Medical Policy Committee review
09/20/2017	Medical Policy Implementation Committee approval. Policy coverage changed to follow AIM Guidelines.
11/15/2017	Coding update
Next Scheduled Review Date:	09/2018

### **Coding**

*The five character codes included in the Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT)<sup>®</sup>†, copyright 2016 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.*

*The responsibility for the content of Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines is with Blue Cross and Blue Shield of Louisiana and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of Blue Cross Blue Shield of Louisiana Medical Policy Coverage Guidelines should refer to the most current Current*

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.





# Louisiana

## Stereotactic Radiosurgery and Stereotactic Body Radiotherapy

Policy # 00045

Original Effective Date: 03/25/2002

Current Effective Date: 12/01/2017

*Procedural Terminology which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.*

*CPT is a registered trademark of the American Medical Association.*

Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	32701, 61796, 61797, 61798, 61799, 61800, 63620, 63621, 77370, 77371, 77372, 77373, 77387, 77432, 77435
HCPCS	G0339, G0340, G6001, G6002, G6003, G6004, G6005, G6006, G6007, G6008, G6009, G6010, G6011, G6012, G6013, G6014, G6016, G6017
ICD-10 Diagnosis	All related diagnoses

**\*\*Medically Necessary (or "Medical Necessity")** - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

**NOTICE:** Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

©2017 Blue Cross and Blue Shield of Louisiana

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Blue Cross and Blue Shield of Louisiana.